NADA
network of alcohol and other drugs agencies

Portfolio Committee No. 2 – Health and Community Services

Submission to the inquiry into the provision of drug rehabilitation in regional, rural and remote NSW

December 2017

The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for the non-government alcohol and other drugs sector in NSW.

NADA's goal is to lead as a member driven peak body, building sustainable non government alcohol and other drug organisations to reduce alcohol and drug related harms to individuals, families and communities in NSW.

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ABOUT NADA

The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for the non-government alcohol and other drugs sector in NSW. Our vision is a connected and sustainable sector providing quality evidence based programs to reduce alcohol and drug related harms to NSW communities.

We represent approximately 100 organisational members that provide a broad range of services including health promotion and harm reduction, early intervention, treatment and aftercare programs. Our members comprise of services that are diverse in their structure, philosophy and approach to alcohol and other drugs service delivery. NADA provides a range of programs and services that focus on sector and workforce development, information management, governance and management support, sector representation and advocacy, as well as actively contributing to public health policy.

NADA is governed by a board of directors elected from the NADA membership. We are accredited under the Australian Service Excellence Standards.

Further information about NADA and our programs and services is available on the NADA website at www.nada.org.au.

PREPARATION OF THIS SUBMISSION

NADA has developed the following submission for the Portfolio Committee No. 2 – Health and Community Services inquiry into the provision of drug rehabilitation in regional, rural and remote NSW. The comments provided in this submission have been prepared by NADA staff, on behalf of its members, and has been endorsed by the board of directors.

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NADA'S REPONSE TO THE TERMS OF REFERENCE

1. The range and types of services including the number of treatment beds currently available

NADA represents approximately 100 NGOs across NSW. Fifty-five of these organisations are specialist alcohol and other drugs (AOD) service delivery providers, with the remaining providing AOD services as part of another broader program area. A full range of AOD services are provided by these organisations and NADA has developed a taxonomy of the AOD interventions provided at Appendix 1.

NADA has analysed its membership database to determine the number of AOD specialist NGOs in regional, rural and remote NSW and has identified 38 organisations providing primary AOD services. As with the broader state-wide membership, these agencies offer a broad range of AOD services to the communities they serve. This includes:

- Detoxification (withdrawal management) programs
- Residential rehabilitation programs
- Outpatient counselling
- Outpatient day programs
- Aftercare, ongoing psycho-social support and telephone support services are provided within the context of all the above service types.

A comprehensive set of treatment service specifications have been developed for all the above service types by NADA and endorsed by the NSW Ministry for Health and is part of the Ministry's published material on the NSW drug and alcohol program. The *NGO Alcohol and Other Drugs Treatment Service Specifications*[1] aim to provide guidance to both purchasers and providers of NGO services regarding the principles and key elements of different types of AOD treatments.

In terms of residential rehabilitation services in regional, rural and remote NSW there are twenty NADA members providing this service type. These include programs for Aboriginal treatment populations (n = 5), women's only treatment (n = 1), youth only (n = 2), with the remainder being all adult populations. NADA estimates that the total number of residential rehabilitation beds available in regional, rural and remote NSW is approximately 420.

The remainder of these regional, rural and remote AOD services being outpatient counselling, outreach and support, inpatient detoxification (n =3), outpatient detoxification (n = 2), youth focused special counselling and support services, Aboriginal community controlled health services and women's only AOD counselling services (n = 1).

[1] http://www.health.nsw.gov.au/aod/resources/Publications/treatment-service-specifications.pdf

Number of treatment episodes as reported to NADA through the National Minimum Data Set

The following data is sourced from all NADA member services who routinely enter their client treatment data into the NADAbase[2] and represents Alcohol and other Drug Treatment Services National Minimum Data Set (NMDS) data for 2016/17.

Table 1: NSW NGO AOD NMDS data for 2016/17[3]

Item	All NSW	Regional, Rural, Remote NSW
Treatment services in NADAbase (n)	124	49
Episodes of treatment (n)	14 500	7043
Own substance use	96%	99%
Males	62%	64%
Females	38%	36%
Identify as Aboriginal	16%	21%
English as preferred language	98%	99%
Residential treatment episodes	32%	38%
Community-based (non-residential) episodes	58%	52%
Principal drugs of concern		
Methamphetamine	35%	34%
Alcohol	29%	35%
Cannabis	17%	14%
Heroin	7%	4%
Other drug of concern		
Nicotine	22%	29%
Cannabis	21%	22%

2. Specific details regarding rehabilitation services for those with amphetamine and methamphetamine ("ice") addictions

The data below are from the same period as the above data set, sourced through NADAbase and show the main treatment type provided to people accessing treatment where methamphetamine/amphetamine was identified as either their principle drug of concern or other drug of concern:

Table 2: Main treatment provided where methamphetamine is identified as the principal drug of concern for 2016/17

Item	All NSW	Regional, Rural, Remote NSW
Assessment only	34%	31%
Rehabilitation activities	28%	29%
Counselling	15%	11%
Withdrawal management (detoxification)	8%	11%
Consultation activities	7%	12%
Support and case management only	4%	5%
Day program rehabilitation activities	3%	0.8%
Information and education only	1%	0.2%

[2] NADAbase is NADA's online data collection system used by the NGO AOD sector to collect the NMDS and client outcome data

[3] The data represents approximately 80% of NSW NGO AOD Services

The above data indicate that of the two main service types – residential rehabilitation and outpatient counselling 28% of all clients receiving treatment in a residential rehabilitation service and 14% of clients in outpatient counselling identify methamphetamine/amphetamine as their primary and or other drug of concern.

Given the above, it is clear that methamphetamine dependency may account for a substantial percentage of clients accessing NGO drug treatment. However, it must be noted that the vast majority of all drug and alcohol treatment clients are poly drug using individuals, that is they use a number of substances simultaneously.

NADA maintains that it is the broad philosophy of the NGO treatment sector to address all drug types for clients in treatment and that the focus should be on the client and not the drug/drugs they are using. This is certainly true for residential rehabilitation treatment programs where the focus is on the therapeutic interventions and psycho-social processes that support clients to reach their own treatment goals.

3. The qualification to receive funding as well as the funding arrangements for services be they public, not-for-profit, for profit or on any other basis

All NSW NGO AOD specialist service providers have successfully demonstrated their ability to provide AOD treatment through multiple successful open tender arrangements with both state and commonwealth government funders over the past twenty years. These NGOs are a well-tested market in NSW and are able to demonstrate sound client outcomes.

The following is an example of the type of criteria that NADA members have responded to receive government funding:

- *History of entity's operation and corporate size including staffing and locations of operation.*
- *Detail of the full range of programs and services currently provided including service cohort - For each program provided by your organisation please fill in the template below, copy and paste table as many times as required if more than one program is delivered.*
- *Current financial sustainability including total funding for previous year indicating specific source (e.g. State, Commonwealth, private and/or community).*
- *Provide evidence of effective operation for each program including outcomes measures used by the organisation and examples of good outcomes for participants under the program.*
- *Details of corporate governance arrangements including accreditation, quality assurance, internal controls, incident and risk management systems.*
- *Demonstrate an understanding of clinical governance as it applies to the providers of AOD services you intend linking with.*
- *Details of staff qualifications and skills plus ongoing training and support arrangements.*
- *An explanation of the data collection system you will put in place to measure program activity and outcomes.*[4]

Additionally, all state and commonwealth government funded NGO AOD treatment providers are required to be in a recognised formal accreditation program with an external accreditation/quality improvement provider.

[4] Taken from the most recent open tender from the NSW Ministry of Health for the delivery of Continuing Coordinated Care in NSW

In NSW, all NADA members who are holding funding agreements with the NSW Ministry for Health as well as the Commonwealth Department of Health or Primary Health Network commissioners are predominately engaged with either the Australian Council on Healthcare Standards or Quality Innovation Performance and have achieved accreditation, or are currently working towards formal accreditation. These accreditation level qualifications include a demonstrated capacity for:

- corporate and clinical governance
- financial and budget management and sound financial record keeping and reporting
- compliance with all appropriate legislation and other compliance mechanisms mandated by the state/territory/commonwealth jurisdictions
- evidence based program service delivery
- appropriately qualified staff and staff support and development processes
- program planning and development and review processes
- staff, client and consumer safety and appropriate facilities
- consumer involvement in the delivery and management of the program and consumer safety
- Community and stakeholder relationships and service linkages.

4. Registration and accreditation process required for rehabilitation services to be established

There is no specific registration process for AOD services in NSW and as mentioned above there are no formal registration requirements by the NSW government to establish residential or outpatient AOD treatment service in this state. NADA does not have a formal view on the establishment of such a formal registration process in this regard. Having said this, we do believe that all external to government organisations that may wish to establish such services should be required to register this intention with the NSW Ministry for Health and seek advice on the appropriate steps in relation to providing such services.

The accreditation process for NSW NGO AOD providers is outlined above, with regard to the qualification to receive funding.

5. The cost to patients/clients, including fee structures provided to families, for accessing rehabilitation services

NGO AOD service providers in NSW do not offer their services on a "fee for service" basis to clients wishing to enter a program. In residential care, it is common practice for providers to seek, with the client's consent, a proportion of their Centrelink payment, as a client contribution, to support the service to provide all accommodation, meals, entertainment, transport and other non-therapeutic services. This usually amounts to between 50 and 80% of their benefit payments and the remainder is managed with the client. The client is assisted with budget planning and overall money management as part of this process.

There are two key outcomes from this client contribution process, firstly, the client is actively contributing to the costs of their own treatment at no financial hardship to them as all their accommodation and living needs are meet by the treatment service. Secondly, the client learns the value of paying for positive a living/learning program and are therefore invested in their own treatment. Finally, it assists the residential rehabilitation

service providers to meet the costs of building, consumables, and client related costs that are not meet by the government funding provided through the service contracts mentioned earlier in this submission.

This client contribution arrangement has never been a barrier to access residential treatment and in cases where clients cannot make the contribution, it is generally waived so that the client can enter the program. Client contributions are not required for NGO outpatient services provided to individuals or families where those services exist across the state.

6. The waiting lists and waiting times for gaining entry into services

The issue of waiting lists for health services is a broad and complex one, highlighting the fact that there are never enough resources to meet the total populations demand for health services. This is especially true for AOD treatment services where the issue of the inadequacy of the funding base for these services is particularly critical. It is well accepted across the AOD specialist field that demand exceeds availability of treatment places. The recent study by the University of New South Wales Drug Policy Modelling Program estimated '*that between 200,000 and 500,000 more people would be in treatment if demand were to be fully met. This means that current met demand may vary between 26% and 48% of all people who will seek, and are appropriate for, AOD treatment'*[5]. The study demonstrated the need for increased funding of AOD treatment to meet the needs of the Australian population.

As a result of a demonstrably underfunded sector, waiting lists are common and prioritising clients in need is a challenge. Referrals to NGO AOD treatment services occur through the following ways:

- Self-referral
- Referral from a relative or friend
- Referral from one treatment or other service provider to an AOD treatment provider
- Referral from the criminal justice system, either through a formal court diversion program or from probation and parole/community corrections.

NSW NMDS data show that the vast majority of referrals to NGO AOD treatment services occur through client self-referral (39%).

The management of client waiting lists is governed by each individual NGO treatment organisation and is largely shaped by the need to respond to priority populations (Aboriginal Australians, pregnant women, women with children, young people, and people living with HIV are some examples). However, other considerations may include:

- The continued increase in demand for residential treatment being experienced by residential treatment providers across NSW
- Mental health, homelessness and/or potential for physical health risks
- Residential services may require proof of detoxification – 3-7 days substance free for example
- Some services may require regular contact from prospective clients while waiting for a place to become available.

[5] New Horizons: The review of alcohol and other drug treatment services in Australia (2014). DPMP, UNSW.

NADA recommends that work is done in consultation with the sector to establish definitions, and standards in relation to the management of waiting lists to ensure consistent monitoring and review.

In terms of meeting the demand for AOD treatment services in regional, rural and remote areas of NSW, NADA argues that significant new resources are required for those NGO specialist AOD treatment providers. We are quite certain, based on the feedback from our regional, rural and remote members, that waiting lists are a more significant issue for their services as there are far fewer options for referral to other treatment services in rural NSW. NADA argues that it should be a priority for new funding to be made available for regional, rural and remote NGO AOD treatment services to assist with meeting demand for services. This would also relieve the necessity of travelling to Sydney or another large regional centre to access AOD treatment for people living in regional, rural and remote NSW.

7. Any pre-entry conditions for gaining access to rehabilitation services

The pre-entry conditions for accessing NGO AOD treatment services, and residential rehabilitation in particular, are for those people seeking treatment to demonstrate a significant history of problematic drug and/or alcohol use, and a desire to undertake treatment. Detoxification is often a prerequisite to entering a residential rehabilitation program in NSW in order to address issues associated with acute physical symptoms of dependence. Withdrawal management requires a particular medical intervention that may not be available in residential rehabilitation services, and the client may not be able to fully participate in the treatment program due to the physical response to withdrawal from alcohol and other drugs.

All AOD treatment programs in NSW are based on the consent of the client wishing to enter these programs, that is, they are voluntary programs. NADA believes that this is the most appropriate way to ensure the optimum program outcomes for both the client. There is one exception, the Involuntary Drug and Alcohol Treatment program (IDAT) which has specific legislation under which prescribed treatment populations (individuals) are coerced to undergo involuntary treatment under this program.

8. Investigate the evidence regarding the efficacy and impacts of mandatory detoxification programs for those who self-harm or are subject to an Apprehended Violence Order (AVO);

NADA has no response to this item.

9. The gaps and shortages in the provision of services including geographical, resources and funding

NADA has produced a comprehensive policy paper for government on implementing a sustainable AOD service system in NSW entitled Healthy Partners[6]. In the paper, we argue that the initial start point for the calculation of necessary funding for a given area of health policy is population need, and this should also apply to AOD health services. This has not been the case for AOD, with funding decisions in this program area largely politically determined based on community concern, and to a lesser extend growth funds within the health portfolio.

[6] Healthy Partners: Implementing a connected and sustainable system to reduce alcohol and drug related harms in NSW http://www.nada.org.au/media/66079/nada_position_paper.pdf

We argue that makes for re-active funding policy and means that available funding is less than estimated need by a considerable amount. It also means that capacity does not exist in service delivery when there are surges in demand for treatment based on changed drug market factors.

A number of years ago, NADA members participated in the development of the National Drug and Alcohol Clinical Care & Prevention (DA-CCP) Project modelling tool, now renamed the *Drug and Alcohol Service Planning* (DASP) model. The DASP was commissioned by the now defunct Ministerial Council on Drug Strategy, a COAG sub-committee. The work associated in modelling community need was completed and endorsed by the Council, however has not been taken up as the model for funds allocations to the AOD program.

NADA would encourage the Health and Community Services Portfolio Committee No 2 to apply pressure to the NSW government to apply the DASP for the purpose of effective AOD services planning.

NADA has undertaken its own modelling for the service types traditionally provided by the NGO sector. NADA has developed its own taxonomy for these service types and this is provided at Appendix 1. NADA has also developed a set of Treatment Services Specifications underneath this taxonomy and this has been endorsed by the NSW Ministry for Health. These tools can also be used to support the planning and funding of AOD treatment.

NADA has assessed the population need for services on the basis of the DASP modelling. The DASP tool allows for calculation of the amount of activity that needs to be delivered across a program area to meet the demand in the population. This can be aggregated up to resource units if desired, or funded as activity and left to service providers to determine the resource units required.

The following table indicates the presumptions that underpin the need for treatment in NSW based on population surveys such as the Australian Burden of Disease study.

Table 3: Population Prevalence and Treatment Rates

Drug	Population Prevalence %	Assumption of Moderate/Severe Misuse Treated Rate	Assumption of Overall Prevalence Treated Rate %
Alcohol	8.8	50%/100%	35
Amphetamine	0.7	50%/100%	95
Benzodiazepines	0.4	50%/100%	45
Cannabis	2.25	50%/100%	35
Opiates – non-medical use	0.75	50%/100%	95

The above figures reflect the fact that although there are people with moderate illnesses who are in need of treatment, many don't seek treatment. The modelling of appropriate levels of service activity to be purchased for the AOD program is predicated on fifty per cent of these people seeking treatment. A small percentage of those with mild illnesses will seek treatment but generally from community services, general practice and allied health, and not from specialist AOD treatment services.

Using residential rehabilitation as an exemplar, and a NSW population estimate of 7.6 million people, it is possible to estimate the number of people across all drug types that would require residential services in NSW, by separating out the diagnosable populations into mild, moderate and severe illnesses. By using the available drug dependence population prevalence data, matching illness severity to treatment need, and applying an appropriate average length of stay consistent with the range of therapeutic models in NSW residential services, it can be demonstrated that NSW requires 1700 residential rehabilitation beds to provide the number of episodes of care necessary.[7] This number is far short of current treatment availability of approximately 700-800 beds available, as calculated by NADA as a good working estimate.

Conservative estimates using DASP population need modelling, modified by expected demand, and applying estimates of actual cost, indicate a deficit in current budget terms, across the entire program, of approximately $40 million per annum. Existing waiting lists for services such a residential rehabilitation, aftercare and opioid substitution further support this deficit.

NADA recognises that such a significant deficit cannot be met in the short term, financially and also in terms of workforce and infrastructure planning, however, government is in a position to commit to long term planning to address the deficit and deal with the need across the community. There are clear economic and social benefits to doing so, not the least of which is that people who use drugs are the 'foot soldiers' of the supply network. Significantly reducing the user population in a given geography can substantially change the economics of supply in that locality, be it a state or a smaller geographic unit.

10. Issues relating to the provision of appropriately qualified health professionals to fill positions in rehabilitation services

NADA has had a long history in the development and delivery of workforce development across the NGO AOD sector in NSW. NADA has recently conducted a workforce audit to determine the number and character of then specialist AOD workforce of its membership. In terms of the question "Who is the NGO AOD workforce?" the following is a snapshot:

The NSW NGO AOD sector employs approximately 1,000 people, over half (59%) of whom are female and over half (56%) of whom are aged 45 years or over. Only a small number (7%) of staff identify as being of Aboriginal and/or Torres Strait Islander background.

Alcohol and Other Drugs Worker is the most common occupation (19.8%) and the majority (82%) of staff work for an organisation providing residential rehabilitation services and 37 per cent work in a major city. While most staff are employed full time (55%), 33 per cent work on a part-time basis and 12 per cent work on a fixed-term contract, casual or other basis.

The average length of time that staff work in the sector is 7.7 years (5.5 years with their current organisation). Almost half (48%) of the workforce hold a university qualification (i.e. undergraduate degree, graduate certificate, graduate diploma, master's degree or PhD/doctorate), and 40 per cent hold a specific AOD qualification. Those who do not possess AOD specific qualifications tend to possess qualifications in

[7] This is a preliminary estimate using the type of methodology and assumptions that underpin DASP.

community services, psychology, social work or counselling. Compared to the national AOD workforce profile, NSW has a higher number of people working on a less than full-time basis (45% in NSW compared to 30% nationally) and a lower number of people who possess tertiary-level qualifications (48% in NSW compared to 65% nationally). Having said this, it is clear that the NSW NGO AOD workforce is a highly qualified and experienced industry grouping.

In terms of workforce challenges, NADA has identified the following key issues that need to be addressed to ensure the ongoing viability and health of the specialist NGO AOD workforce in NSW:

- The workforce is ageing, the majority are female and there is limited cultural diversity. These factors have a number of workforce development implications.
- The critical need for increasing the Aboriginal and Torres Strait Islander workforce.
- Succession planning and recruitment and retention challenges could mean the sector will face major shortages as workers approach retirement age and there is increased competition for staff.
- Inconsistencies in industrial awards and unequal pay compared to the government sector continue to be issues for the sector in terms of recruitment and retention of staff.
- There is a need to better understand how people with lived experience identify in the workforce so that adequate support can be provided, and so that lived experience, or the peer workforce, can be properly valued and supported into the future.
- There is limited education and training options specific to AOD at university level.
- Those working less than full time and those living in regional and rural areas are particularly affected by unequal access to training and professional development.
- The lack of an agreed NGO AOD worker role definition, along with qualification and accreditation issues, is contributing to the lack of acceptance of AOD workers as "professionals" who are an important and valued part of the broader health system.
- Access and funding of appropriate clinical, and other supportive, supervision.
- Maintaining the evidence base and transfer of knowledge and skills for the range of complexities and responses required can be a challenge for individual services and the sector as a whole.

To address these challenges NADA argues that the NSW Ministry for Health establish a comprehensive AOD workforce development strategy underneath the pending NSW AOD strategy. This workforce strategy should also be resourced with a sufficient budget to support education, training and development activities of workers in the field, the development of organisational capacity development programs and most importantly, lift the wage/salaries levels of the most underpaid sections of the NGO AOD workforce.

11. Evidence of rehabilitation services that have had both successful and unsuccessful outcomes, including what characteristics constitute a successful outcome and how reliable is the data collection and reporting mechanisms currently in place

Since 2008 NADA has promoted a culture of outcome measurement among its members via an online client data management platform – NADAbase, that is supported by training and consultation. Additionally, some NGO AOD services have developed their own client data management platforms to support outcome measurement.

In addition to the routine collection of client and treatment-related data (Commonwealth and State Minimum Data Sets for Alcohol and Other Drug Treatment), all NADA members who provide residential treatment and

provide data to NADA also collect outcomes data with a focus on the four domains contained in the NADAbase:

Outcome domains measured	**Tool used**
Alcohol and Drug use frequency and dependence	• Alcohol and drug use frequency (AATOM and BTOM elements • Severity of Dependence Scale (SDS)
Mental Health	• Kessler-10
General Health and Wellbeing	• WHO Quality of Life – 8 (EURHOS) • Current court matters • Living arrangements
Blood Borne Virus and Overdose Risk	• BTOM-C elements

Other outcomes related to targeted programs include, but not limited to, keeping children out of 'out of home care' by women's specialist AOD services, and connection to country for Aboriginal Community Controlled Organisations.

Successful outcomes for residential treatment use validated self-reported improvements measures on the domains outlined above – in conjunction with program completion and length of stay. For example, those that remain in treatment until either the program is completed or there has been a case review and referral to community-based supports would be considered a successful outcome, in accordance with the goals identified by the individual client. Each NSW Health funded residential rehabilitation service provides reports to funding bodies regarding client outcomes, and client data is usually accompanied by case studies of client experience to provide context. Approximately 60% of residential rehabilitation services provided in NSW have also engaged in either internal or external (in partnership with universities) evaluation processes of their programs which are either detailed in annual reports and or peer reviewed journals.

Data collection and reporting support is a key function of NADA – which includes important infrastructure support. This means that we can have confidence as a peak organisation in the quality and timeliness of data being provided to funders at both the state and commonwealth level.

Additionally, NGO AOD treatment providers in NSW have also undertaken (or have commenced) specific new outcomes evaluation or trialling innovative new approaches to treatment through the NSW Health Alcohol and Other Drugs (AOD) Early Intervention Innovation and Evaluation Fund. This new funding stream has provided opportunities for NGO service providers to undertake targeted evaluations of their service delivery models identifying specific health outcomes for their clients that will make significant contributions to the evidence base for AOD treatment. NADA and the Ministry for Health will be reviewing the results of these evaluations and innovation research projects that will feed into the future planning and identification of evidence-based interventions for their programs.

12. Current and potential threats to existing rehabilitation services

There are a number of threats to the sustainability of the residential rehabilitation treatment sector in NSW. the first and most significant is the lack of any new resourcing for the primary function of residential rehabilitation services, that is bed capacity and the associated costs with the provision of this basic component

of service delivery. Since the early 2000's, no new state or commonwealth funding has been made available for an expansion of the number of rehabilitation beds the sector is able to provide. In fact, the amount of bed provision has been effectively reduced due to the increase in operating and compliance costs on NGO AOD treatment service providers.

As is the case with hospital beds, it is not the physical bed per se, but the number of appropriately qualified staff and other program resources to provide the support services to clients occupying the beds. The main reason we have a stagnation or in some cases a reduction in the number of beds the sector is able to provide is that resources for the provision of direct services to clients has been shifted to back office administration / financial and compliance functions in order to meet the reporting requirements of both state and commonwealth funding contracts. NADA maintains that there is an urgent need for government to provide the resources to enhance the number of beds the residential rehabilitation sector can provide across NSW. This is particularly important for regional, rural and remote NSW, where, as stated earlier, there is the biggest need for service delivery expansion.

Also of critical importance is the need to expand culturally appropriate treatment options for Aboriginal and Torres Strait Islander people, particularly for women, where there are limited options available. There are a number of Aboriginal Community Controlled AOD Treatment Services in NSW that exist in regional, rural and remote NSW that are well networked, but are not able to meet the demand. Both residential and non-residential options need to be made available, that are family inclusive and trauma informed.

The maintenance and expansion of the specialist AOD workforce is another key threat to the rehabilitation and broader treatment sector in NSW. As discussed in question 10 of this submission, the AOD workforce is aging and recruitment and retention are difficult in our sector due to the social stigma of the client group we treat, the comparatively low level of remuneration and in rural, regional and remote areas of NSW these issues are even more pressing. As previously stated, the availability of resources and qualified staff to run out services is more acute in country and remote NSW due to the lack of service infrastructures and the lack of specialist support services that are available in the cities and large regional centres of NSW. There also needs to be consideration given to the establishment of new treatment service sites in regional, rural and remote NSW. These new sites could be found in the existing spare capacity of Health Department or LHD owned and run sites and done in partnership with NGO AOD service providers who could more quickly establish new treatment programs including residential and outpatient services which could be run out of the same service infrastructure.

Based on the projected population need modelling estimates outlined earlier in this submission, we estimate that an additional $40 million dollars of program funding be added to the current state AOD budget (approximately $230 million) to meet the deficit need across the treatment service sector. A priority could be given to the establishment of new treatment services in regional, rural and remote NSW. A focus of any services should also address the need for culturally appropriate care, as outlined above.

13. Potential and innovative rehabilitation services and initiatives including naltrexone

As stated previously in this submission, the treatment programs provided by the NGO AOD treatment sector in NSW are evidence based and are continually being developed and refined by practitioners and service planners across the sector. This is supported by the clinical services development programs and workforce

development programs provided by NADA to its membership, through active engagement with the three national drug and alcohol research centres and through the support structures of the state's AOD Program. Additionally, NADA has established a research network [8]with the mental health peak which aims to build the research capacity of both the NGO AOD and mental health sectors.

NADA supports a Practice Leadership Group which is a grouping of senior clinicians from across our membership, which provides advice, and supports the dissemination of evidence based and best practice treatment initiatives and clinical practice. The Quality in Treatment Sub-committee of the state's Drug and Alcohol Program Council is another structure which supports the dissemination of clinical best proactive and innovation across both the government and NGO AOD treatment sector.

Formal linkages to other key learning and development agencies like the Agency for Clinical Innovation also assists the NGO AOD treatment sector to access clinical partnerships which assist in further ongoing treatment innovation. As reported earlier, the NGO AOD treatment sector is also actively involved in research and evaluation activities that not only contribute to the evidence base but also lead in building that evidence base.

With regard to Naltrexone, NADA understand that Naltrexone is currently a treatment prescribed for alcohol dependence. However, NADA does not believe that there is sufficient evidence for the inclusion of Naltrexone based treatment interventions as a priority, particularly as it relates to opioid withdrawal. This is based on the widely held view within the public and NGO clinical community, and the relevant international literature, that this specific pharmacological intervention is not in and of itself a curative treatment option.

14. Any other related matters

NADA believes that an appropriate population needs based planning model (DASP), already developed and owned by NSW Ministry for Health, be implemented across the state. This would build on the current NSW AOD strategy and would form the basis for an associated cost modelling approach to the expansion of the current AOD budget as noted earlier.

There is an urgent need to develop a joined-up approach to the management of the NGO AOD budgets between the state and commonwealth governments. NADA believes there would be a great advantage in the better alignment and integration of both the state and commonwealth NGO drug budgets. Both these budgets account for approximately 80% of the total funding to the specialist NGO AOD sector in NSW and it would make sense to have these budgets better aligned in order to identify the most appropriate service delivery outcomes being delivered across the main treatment service types.

It is also important to have greater budget transparency between the state and commonwealth NGO AOD budgets given that the commonwealth has shifted much of the responsibility for the management of its NGO budgets to the Primary Health Networks (PHNs) nationally. NSW PHNs operate in the same geographical space as the LHDs and this means there is more opportunity for a joined up approach to funding the same NGO treatment agencies by both the LHDs and PHNs to meet local population needs.

[8] Community Mental Health Drug and Alcohol Research Network - http://www.cmhdaresearchnetwork.com.au/

CLOSING COMMENTS

NADA believes that the specialist NGO AOD treatment sector has a proven, evidence based track record in the provision of AOD treatment and support services across NSW. In particular, we are able to identify the provision of high quality, research driven AOD service delivery in regional, rural and remote NSW by key NGO services providers who have decades of experience in these regions.

In order to support the continued development of evidence based treatment services in regional, rural and remote NSW

As outlined in this submission, NADA would like the Health and Community Services Portfolio Committee No 2 to:

1. Apply pressure to the NSW government to apply the DASP model for the purpose of effective AOD services planning, as outlined in NADA's Health Partners Position paper.

2. Increase funding to residential beds in regional, rural and remoted NSW to address bed shortages, which has been projected to be an additional $40 million.

3. To address workforce challenges NADA argues that the Committee request the NSW Ministry for Health establish a comprehensive AOD workforce development strategy.

NADA would welcome further opportunities to discuss or expand upon this submission with the Parliamentary Joint Committee.

APPENDIX 1: NSW NON GOVERNMENT AOD SERVICE TAXONOMY

Service level and intensity	Harm Reduction LOW →	Health Promotion and Harm Prevention MEDIUM →	Treatment HIGH →	Treatment + HIGH + →	Extended and Continuing Care MEDIUM
Service type	Needle and syringe program Brief intervention - information and education	Health promotion and prevention - information and education Health promotion and prevention - community development	Case management Psychosocial counselling Withdrawal management Rehabilitation day program Residential rehabilitation Opioid treatment program	As for treatment plus: Specialist programs (ie residential family, residential women with dependent children, Indigenous, residential pharmacotherapy stabilisation or reduction)	Case management Psychosocial counselling Supported living/ transitional housing program
Service setting	Needle and syringe centre Community based health centre Health, welfare and homelessness service Youth service Aboriginal Medical Service Schools Community events	Specialist drug and alcohol service – out-client Community based health centre Health, welfare and homelessness service Youth service Aboriginal Medical Service Schools Community events Social media	Specialist drug and alcohol service – out-client and out-reach Specialist drug and alcohol service – residential detox Specialist drug and alcohol service – residential	As for treatment	Specialist drug and alcohol service – out-client and out-reach Supported living/ transitional housing
Workforce	- Health education officer - Community development officer - Welfare/youth worker - Drug and alcohol worker/counsellor - Aboriginal health worker - Peer worker	Drug and alcohol specialist knowledge and skills required. - Health education officer - Community development officer - Welfare/youth worker - Drug and alcohol worker/counsellor - Aboriginal health worker	Drug and alcohol specialist knowledge and skills required. - Drug and alcohol worker / counsellor - Aboriginal health worker - Mental health worker /counsellor - Psychologist - Social Worker - Nurse - General /medical practitioner	As for treatment	Drug and alcohol specialist knowledge and skills required. - Drug and alcohol worker/counsellor - Aboriginal health worker - Mental health worker /counsellor - Psychologist - Social Worker
Population & drug use focus	Individuals, families and communities Pre and contemplative, experimental and regular drug use Injecting drug use	As for harm reduction plus: Problematic drug use. At risk individuals and groups	Individuals and families. Problematic or dependent drug use. At risk individuals and groups	As for treatment plus: High complex health and social needs: - Women and parents with children - Coexisting mental health issues - Cognitive impairment - Acute physical health issues - Criminal justice connection - Trauma histories	Individuals and families Problematic or dependent drug use At risk individuals and groups